Northwest Family
CHIROPRACTIC & MASSAGE

New Client Registration Form (please complete entire form)

Today's Date:_____ Primary Care Provider:_____ Phone #:_____

Client Information:

Legal Last Name:_____ Legal First Name:_____ Middle Initial:____

Nickname:_____ Former Name:_____

Relationship status: single / married / divorced / separated / widowed

Birth date:_____ Age:_____ Sex: Male / Female Occupation:_____

Home phone #:_____ Cell phone #:_____ Work phone #:_____

I would like text message reminders for my appointments sent to my cell phone # provided above: Yes / No

Emergency Contact:_____ Phone #:_____

Billing address:_____ City:_____ State:_____ Zip:_____

Email Address:_____ Email reminders? Yes / No

How did you hear about the office? _____

Are you covered by medical insurance? Yes / No

Does your insurance require a referral from your Primary Care Provider? Yes / No (Please ask front desk for more info if needed)

Primary Insurance:_____

Subscribers Name:_____ Subscribers date of birth:_____

Clients relationship to insurance subscriber: self / ☐ ☐ spouse / child / domestic partner / other:_____

Who is the financially responsible party for the bill? Self Other: (Please fill out below)

Name:_____ Date of birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Employer:_____

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefits program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefits program to release information to you regarding my coverage
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept assignment of benefits, or if payments are made directly to me or my representative I will endorse such payment to you.
4. I understand and authorize release of all health information about me to my insurer, health plan, employer program or similar benefits program identified above to obtain payment for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

Client / Guardian Signature:_____ Date:_____

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PEDIATRC INFORMATION FORM (BIRTH-5YEARS)

Client's Name: _____ Date: _____Date of birth: _____

What is the primary reason that you are seeking Chiropractic care for your child?

_____

When did it begin? _____
Is it getting worse? Yes / No
What makes it better? _____
What makes it worse? _____
Does it affect their daily activity? □ Not at all □ Somewhat □ Always
Which activities are affected? _____

Prenatal History:

Any complications during pregnancy: _____
During pregnancy did the mother:
Use any alcohol? Yes / No Any tobacco? Yes / No Any vaccines/medication? Yes / No
Reason for vaccines/medications: _____
Illness/infections during pregnancy: _____
Supplements during Pregnancy:_____
Ultrasounds or other testing: _____
What things were done to stay healthy during pregnancy?

_____
_____

Birth History:

Place of birth: □ Home □ Birthing Center □ Hospital
Provider: □ Midwife □ OB-Gyn □ Other
Type of birth: □ Vaginal □ Cesareans
Duration of gestation: _____Weeks
Duration of birth:_____
Were pain medications used? Yes / No Pitocin used? Yes / No
Was labor induced? Yes / No If yes, why? _____
Birth trauma? □ Doctor assisted □ Twisting/Pulling □ Vacuum Extraction □ Forceps
APGAR score if known: _____
Did your child have a misshaped skull/head? Yes / No
Did your child have any bruising in the skull/face? Yes / No Where?_____

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Growth and Development:

Was your infant alert and responsive within twelve hours of delivery? Yes / No

If no, please explain:_____
At what age did your child:
Respond to sound:_____ Follow an object:_____
Hold up head:_____ Vocalize:_____
Begin to teeth:_____ Sit up unassisted:_____
Crawl:_____ Walk: _____

Chemical Stressors:

Did you breast-feed your child? Yes / No How long? _____
Was formula introduced? Yes / No At what age? _____
Began solid foods at what age? _____ Type of first food? _____
List any food allergies: _____
Has your child been vaccinated? Yes / No
Reason: □ Informed decision □ Recommended □ Did not know I had a choice
Did your child have any negative reaction to the vaccines? Yes / No
If yes, were they reported? Yes / No
Has your child been on antibiotics? Yes / No
If yes, how often and what purpose? _____
Is your child currently taking any medication? Yes / No
If yes, how often and what purpose? _____
Is your child currently taking any vitamins Yes / No
If yes, please list: _____
How many glasses does your child drink per day? Water ____ Milk ____ Juice ____ Soda ____
Does your child consume artificial sweeteners? Yes / No
Rate your child's diet: □ Well-balanced □ Average □ High sugar/ processed foods
What is your child's favorite food?_____

Client: Please fill out if age 0-5 years
Have any of the following occurred?

Jaundice	Colic	Reflux
Anemia	Frequent Diarrhea	Fall from a changing table
Cyanosis	Constipation	Fall out crib
Seizures	Sleeping problems	Fall off playground
Infections	Frequent fevers	Tumble down stairs
Tonsillitis	Frequent crying spells	Play in Johnny Jumper
Frequent ear infections	Repeated colds	Car accident

Other _____

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Have any of the following occurred?

Fall from a tree	Stomach Pains	Bed-wetting
Fall off a bicycle	Hyperactivity/ Autism	Asthma
Fall on playground	Leg/Knee pains	Allergies
Sports accident	Scoliosis	Growing Pains
Car accident	Learning Difficulties	Headaches/ Migraines

Other _____

Does your child participate in any athletic extracurricular activities? Yes / No

If yes, which ones? _____

Number of hours your child sleeps? _____hours/day

Sleep quality? □ Good □ Fair □ Poor

Is there anything else the Doctor should know? _____

_____

Have you, the child's legal guardian, had any personal experience with Chiropractic? Yes / No

Authorization to Evaluate and care for a Minor

I, _____ the undersigning parent/ guardian having legal custody/ guardianship of _____, a minor, do herby authorize, request, and direct the staff and doctors of Northwest Family Chiropractic & Massage to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Child's name: _____

Parent/ Guardian's signature: _____ Date: _____

Our Mission is to provide a profound health care experience in a professional and genuine environment. We empower our clients through individualized Chiropractic programs and lifestyle coaching and inspire our clients to uncover the natural healing power from within.

Welcome to NW Family Chiropractic & Massage

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FINANCIAL ATTENDANCE & HIPAA DISCLOSURE

Claims Escalation to the Washington State Office of the Insurance Commissioner

In the event of an unreasonable claim denial, unresolvable claims issue, or claim decision that could be a violation of state law; it is possible to escalate claims issues to the Washington State Office of the Insurance Commissioner. In order to solve the issue, the Insurance Commissioner's office does require the patient's name, ID and/or group number, DOB, explanation of benefits, and possible discussion of any claims related communication between the patient, our office, and the insurance carrier.

Please choose from the following options:

- ☐ **Option 1:**
  I give NW Family Chiropractic permission to release my information, as specified above, to the Office of the Insurance Commissioner; in order to resolve claims issues as they deem appropriate.
- ☐ **Option 2:**
  I may release my information to the Office of the Insurance Commissioner but only on a case by case basis. Please seek my written approval for any applicable claims issue.
- ☐ **Option 3:**
  Under no circumstances do I wish for NW Family Chiropractic to release my information to the Office of the Washington State Insurance Commissioner.

The insurance commissioner does not regulate out of state or self-funded health plans.

RELEASE OF PERSONAL INFORMATION **Please initial:** _____

I authorize the release of my information to the following individual (s)

☐ Self only

☐ Other (please write in below)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

MISSED APPOINTMENT FEES

We allocate a specific time for your appointment to better fit your needs. We understand that there may be times when you must cancel or reschedule an appointment but we do request advance notice for the following services:

24 hours advance notice is required to cancel or change a **massage** or incur a **$70.00** missed appointment fee.

Notice **ahead of the scheduled time** to cancel or change a **chiropractic** appointment or incur a **$20.00** missed appointment fee.

Missed appointment fees may not be billed to insurance. **Please initial:** _____

NOTICE OF PRIVACY PRACTICES

I have read the privacy notice & understand my rights. I authorize NW Family Chiropractic to use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations as described in the privacy notice. If you have questions about any part of this notice or want more information about your privacy rights, please contact Marisa De Lisle DC, at 206-363-4478 within 2 working days. If you are not satisfied with the manner that this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

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Insurance Verification Form

Patient Name: _____ Effective date:_____

Insurer: _____ Insurer Date of Birth:_____

Insurance Company Name:_____

Do you have a Secondary Insurance Company?:_____

Dear Practice member. This form is provided for you to document your Insurance Benefits. Over the years there have been many changes in the insurance world, because of that, we ask that you verify your benefit information so you understand how your benefits work.

Please verify this information regarding your Chiropractic Benefit:

Spinal Manipulation: # per year_____

Plan Deductible: _____

(Does the deductible apply to the spinal manipulation visits? YES / NO)

Co-Pay per visit: $_____

Co-Insurance %:_____

Massage Therapy Benefit:_____ Combined with PT: Yes / No_____

<u>Regence plans</u>: do you need pre-certification for spinal manipulations? YES / NO

<u>Premera plans</u>: do you need pre-certification for PT/MT benefits? YES / NO

Some policies will process services from different benefits within the plan. If you would like to have more in depth information regarding your plan we advise that you verify the following:

X-ray Benefit: _____

Examination Benefit:_____

Do any of these benefits apply to deductible? Yes / No _____

If you would like more information about codes we use in office, please ask front desk.

After verifying this information please provide this to the front desk staff